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Psychiatric Treatment: In the Absence of Law?

R (on the application of B) v. Ashworth Hospital Authority and another

[2005] U.K.H.L. 20

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This case concerns the scope of the compulsory treatment provisions of the Mental Health Act 1983. In particular, it determines whether persons confined under that Act may be compulsorily treated for any mental disorder, or only for the form of mental disorder justifying their confinement.

Following a conviction for manslaughter, B was detained at Ashworth Hospital under sections 37 and 41 of the Mental Health Act 1983. The provisions of the Act, both for persons such as B held under section 37 and for persons civilly detained under section 3, require that the individual be categorised as suffering from one or more of mental illness, mental impairment, severe mental impairment or psychopathy. B was diagnosed with schizo-affective disorder, and was therefore categorised as mentally ill. In 2000, he was further diagnosed as affected by personality disorder, and at the end of that year was transferred to a different ward within the hospital for treatment of that disorder. His classification was not however altered to reflect dual diagnosis of mental disorder and psychopathy.

Part IV of the Mental Health Act 1983 concerns the provision of treatment without consent of persons detained either civilly or criminally under the Act. At particular issue was the interpretation of section 63:

The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, not being treatment falling within section 57 or section 58 above, if the treatment is given by or under the direction of the responsible medical officer.

At issue in this case was whether these compulsory treatment provisions extended only to treatment for the classification of disorder for which the individual was confined, mental illness in this case, or whether they could extend to treatment for any mental disorder.

At first instance, Sir Richard Tucker was held that the statutory language allowed treatment for any mental disorder.¹ The Court of Appeal² held unanimously that it allowed only treatment for the classification of mental disorder for which the individual was confined. The hospital appealed to the House of Lords.

Baroness Hale wrote the unanimous judgment of the House allowing the appeal. She gave five reasons relating to strict statutory interpretation for the broader reading. First, 'mental disorder' was a defined term under section 1 of the Act. It was broader in scope than the four classifications, including as well 'arrested or incomplete development of mind' and 'any other disorder or disability of the mind.' Second, when the Act wished to require reference to one of the specific classifications, it used the phrase 'form of disorder', a phrase not used in section 63. Third, section 63 applied as well to persons civilly confined under section 2 of the Act, a section which did not require the patient to be classified according to the four forms of disorder. Fourthly, the statutory history of the classificatory structure indicated that it was relevant to confinement, as it was contained in the Mental Health Act 1959 in that context, and remain relevant in that context as different classifications required slightly different requirements for civil confinement. The structure cannot have referred to the treatment provisions of the current part IV, as these were not introduced until the 1983 Act. Finally, for section 37 patients such as B, the responsible medical officer had never had authority to re-categorise the patient. That was a role reserved for the review tribunal, and it was a process that could take a considerable amount of time. Baroness Hale found it unlikely that the intent of Parliament was to prevent the patient from being treated without consent in this period.³

Baroness Hale further held that as a matter of policy, the categorical structure was too blunt and haphazard an instrument to provide any meaningful protection against inappropriate treatment of the patient.⁴ It would offer a patient no protection from being given the wrong sort of medication, so long as it remained medication for a mental illness. It would instead in this case protect against the inappropriate provision of a talking cure, a treatment which she elsewhere notes does not depend on consent for its legality,⁵ and therefore presumably requiring significantly fewer safeguards than the provision of medication which was not protected. Further, psychiatry was an inexact science, with diseases of the mind intermingling with personality traits. The objective of the psychiatrist should be to treat the whole patient, unimpeded by classifications that were in this context largely irrelevant. The classifications should be kept up-to-date and accurate, of course; but that was to ensure the appropriate tests for confinement were followed, not to dictate the range of available treatment.

PSYCHIATRIC TREATMENT, SAFEGUARDS AND CONSENT

This is a factually peculiar case. It was triggered by a move of B to a personality disorder ward, a location which he found to be more restrictive of his liberty than his

¹ [2002] EWHC 1442.

² [2003] E.W.C.A. Civ. 547.

³ *R (on the application of B) v. Ashworth Hospital Authority and another* [2005] U.K.H.L. 20, para. 22-29.

⁴ *Ibid.* para. 30, 37.

⁵ *Ibid.* para. 10.

previous ward. For this reason, the hospital's case at the Court of Appeal was focussed in part on the non-justiciability of moving people to different wards within a hospital. At the Court of Appeal, however, B made it clear that this was not his concern. Instead, his counsel stated that B's concern was that he was being treated for personality disorder, not what ward he was on.⁶ This does little to clarify the context, however, since as Baroness Hale points out, treatments for personality disorder are talking cures: they cannot practically be pursued without the co-operation of the patient. It is not that B was being deprived of his medication for his mental illness on this ward; rather that he was being offered a talking cure as well. If it is not, in fact, the restrictiveness of the ward, it is difficult to see what the underlying practical issue in the case was from B's perspective. The relevance of the legal question is easier to see for a patient categorised as psychopathic, but treated in addition for mental illness, as treatments for the latter category may well involve medicines or ECT, both of which may have significant adverse effects.

As one would expect from her expertise in the field, Baroness Hale's statutory analysis of section 63 is convincing. It does seem that her view reflects what the Act was meant to say. The judgment is interesting however because of the assumptions it adopts, and its demonstration of how far the law in England and Wales has yet to go to provide a right to meaningful involvement of psychiatric patients in their care. We are clearly in a jurisdiction in which, at least in law, treatment is done on psychiatric patients, not with them.

A point of comparison might be the view of the Committee for the Prevention of Torture, Inhuman or Degrading Treatment or Punishment, the investigative body of the Council of Europe regarding article 3 of the European Convention on Human Rights:

Patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis should not be construed as authorising treatment without his consent. It follows that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances.⁷

The 1983 Act manifestly does not comply with this standard. It would not have complied even had B been successful in the case, as the uncontrolled authority under s 63 to treat him for the category of disorder justifying his confinement can hardly be considered 'strictly defined exceptional circumstances'. The interpretation afforded to the section by the House of Lords allows unfettered treatment of any mental disorder with which the confined patient is affected without the patient's consent, no matter how small or great and whether or not the patient has capacity to consent to it. This throws to the wind any concept of autonomy for the civilly or criminally confined psychiatric patient. Baroness Hale is quite right: the use of the categories as

⁶ *Supra* n. 2., at para. 14.

⁷ Council of Europe, *Report of the Committee for the Prevention of Torture, Inhuman or Degrading Treatment or Punishment*, Council of Europe 2000, at para 41.

a basis of safeguards to limit the treatments which could be provided would be arbitrary and ineffective for the reasons she gives. That is not however an argument for the status quo.

Baroness Hale quite rightly acknowledges that psychiatric patients, and particularly those confined in high security conditions for long periods of time are in a vulnerable situation. She states:

However well-meaning and professional their carers, they do risk being obliged to accept treatment which is inappropriate to their particular needs. But they are already protected by the ordinary law of medical negligence, by the special safeguards in ss 57 and 58 against particularly intrusive or long term treatments, and by the remedies against any treatment decision which breaches their rights under articles 3 or 8 of the European Convention on Human Rights, either under s 7 of the Human Rights Act 1998 or in judicial review.⁸

One cannot but question whether these mechanisms really protect patients against inappropriate treatment provision? A survey of these safeguards suggests they do not.

Section 57 requires both consent of the competent patient and the agreement of a specially approved second psychiatrist (SOAD) prior to treatment by psycho-surgery or the surgical implantation of hormones to reduce male sex drive.⁹ The control on the latter of these treatments has been rendered largely irrelevant, as the courts have held that 'hormone' does not include hormone analogues, even though these are far stronger than the actual hormones. *Stuart-Smith LJ* justified this stating that 'If Parliament passes legislation on the control of leopards, it is not to be presumed that leopards includes tigers on the basis that they are larger and fiercer.'¹⁰ Most are now ingested orally, but even if they are injected by syringe, the same case holds that this is not 'surgical' implantation, and is therefore outside the scope of the section. It is difficult to see this section as creating much of a safeguard.

Section 57, provided that it is indeed engaged, is the only safeguard contained in the Act applying to treatments (with the exception of the administration of ECT) on confined patients in their first three months of treatment. Whenever ECT is offered, and otherwise after the three months from the commencement of the administration of treatment for mental disorder, a treatment plan must be approved by an SOAD under section 58. Research by Fennell indicates that the SOAD approves of the RMO's treatment plan in roughly 96 per cent of cases,¹¹ however, raising a serious question as to how effective a safeguard this is. Some of his more specific findings do not increase confidence. One might expect that polypharmacy might raise particular suspicions, but it seems that only when drugs from four or five BNF categories were prescribed did SOADs raise queries.¹² Recently, the Court of Appeal has required

⁸ *Ibid.* n.2, para. 21.

⁹ The section applies to the latter of these treatments by regulation 16 of the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983.

¹⁰ *R v. Mental Health Act Commission, ex p X* (1988), 9 BMLR 77 at 83.

¹¹ P. Fennell, *Treatment Without Consent* (Routledge, 1996) at 211.

¹² *Ibid.*, at 203.

SOADs to provide reasons for their opinions,¹³ allowing the patient some scrutiny of the process, but judicial review on the basis of unreasonableness will be a high hurdle.

Negligence similarly does not appear to be an effective safeguard. A database search of WestLaw UK and Lawtel using negligence and psychiatry/psychiatrist as search terms turns up very few cases in England and Wales in the last forty years.¹⁴ *Drake v Pontefract Health Authority*¹⁵ is remarkable as the only case on such a search where a psychiatric patient successfully sues for negligence related to inappropriate prescription of medication. In a few other cases where patients or their families successfully sue for injuries or death occurring on wards, medication may be part of the overall picture, but the negligence in question appears to be failure adequately to keep the patient under surveillance. Lawtel's Quantum Reports show another two cases where out-of-court settlements were reached for inappropriate medication, and one for misdiagnosis. It may of course be that other cases would turn up using other search terms, but for medication, negligence appears to be a paper tiger. This is unsurprising. As Baroness Hale states,

[P]sychiatry is not an exact science. Diagnosis is not easy or clear cut. As this and many other cases show, a number of different diagnoses may be reached by the same or different clinicians over the years. As this case also shows, co-morbidity is very common.... It is not easy to disentangle which features of the patient's presentation stem from a disease of the mind and which stem from his underlying personality traits.¹⁶

These conceptual difficulties mean that the threshold to establish a breach of duty of care will be correspondingly high. If diagnosis is neither easy nor clear cut, the margin of judgment allowed to psychiatrists must be correspondingly large. As for medication, the very protections provided by section 58 make a negligence action effectively impossible. How can a claim be made that the psychiatrist is negligent under *Bolam* when an SOAD, an officially selected and trained expert in the field, has signed off the treatment?

The Court's references to section 58 safeguards and negligence miss the point in any event. B's point, it would seem, was that he ought to have some control over at least some of the psychiatric treatments to which he was subjected. Insofar as they are effective at all, the SOAD process in section 58 and the tort of negligence ensure *standards* of treatment; they do not provide B with any meaningful role in decision-making *about* that treatment. The complexities and lack of clarity in psychiatric practice strengthen rather than weaken the case for such involvement: if as the Court suggests it is an area where reasonable people can disagree, why should the law silence the patient's voice?

Applications under the Human Rights Act may perhaps offer such a role to B. There has been some progress here, in that the Court of Appeal has held that there is

¹³ *R (Wooder) v. Feggetter and Mental Health Act Commission* [2002] E.W.C.A. Civ 554.

¹⁴ Searches conducted on 27 July 2005.

¹⁵ [1998] Lloyd's Rep. Med. 425.

¹⁶ *Supra* n. 2. at para. 31.

jurisdiction in appropriate cases to hear oral evidence to ascertain whether psychiatric treatment violates a patient's rights under the European Convention on Human Rights.¹⁷ The courts have, however, been reluctant to provide remedies. Where treatment is 'medically necessary', the courts have failed to find the intervention sufficiently severe to engage article 3, even when the treatment is refused by a competent patient. The threshold to engage article 8 is reached more easily. That article will not be breached however if the treatment is 'necessary in a democratic society ... for the protection of health' and 'in accordance with law'. The courts tend to find no violation on this basis, a process assisted by their deference to the respondent doctor's view on disputed issues of fact.¹⁸ The existing law therefore gives the detained patient no control over his or her psychiatric treatment, and dubious legal safeguards as to its quality.

Notwithstanding a critical report on the draft Mental Health Bill from the Joint Scrutiny Committee of the House of Commons and House of Lords,¹⁹ the Government has indicated that it will be proceeding with a new Mental Health Act in the near future.²⁰ Whether this will improve matters is of course difficult to say, as no new Bill has been published since the Government's response to the Joint Scrutiny Committee Report. Assuming (as seems likely) that the next set of reforms resemble the draft Bill published in 2004,²¹ some small advances can be expected. The 2004 Bill at least included a requirement that the patient's clinical supervisor consult the patient (among a number of others) in compiling a care plan,²² and treatment extending after the initial 28 day assessment would only be able to be enforced after a review tribunal hearing.²³ Consultation is not the same as consent, however. In the initial 28 days, there would be no additional safeguards: treatment contained in the plan could simply be enforced on the patient. Beyond 28 days, it is clear that continued compulsory treatment would require the approval of the Review Tribunal. The patient would again have to be consulted prior to any amendments being made by the tribunal. Such amendments would have to be agreed with the clinical supervisor, however,²⁴ creating the possibility of a stand-off between clinician and tribunal. Where the clinical supervisor would have the power to veto amendments, the patient would need only to be consulted. Throughout, the authority to treat compulsorily could extend to any mental disorder affecting the patient; there appears no prospect that *B* will be reversed by implication in any forthcoming statute. Then, as now, it seems that persons whose condition warrants the imposition of any compulsion will lose their right to consent to all treatments relating to their mental disorder. Indeed, the net is if anything widened, as the Bill would allow compulsory treatment in the community. The disorder would no longer, as now, need to be sufficiently severe as to warrant confinement. This is a long way from the Committee for the Prevention of Torture's general right to consent to or refuse

¹⁷ *R (Wilkinson) v Broadmoor Special Hospital Authority* [2001] E.W.C.A. Civ 1545.

¹⁸ See, for example, *R (PS) v. G (RMO) and W (SOAD)* [2003] EWHC 2335 (Admin). For comment analysing the Court's approach in these regards, see P. Bartlett 'Capacity, Treatment and Human Rights' (2004) 10 *Journal of Mental Health Law* 52.

¹⁹ Sess. 2004-5, HL 79 and HC 95.

²⁰ Department of Health, *Government Response To The Report Of The Joint Committee On The Draft Mental Health Bill 2004*, Cm 6624 (The Stationery Office, 2005).

²¹ Department of Health, *Draft Mental Health Bill*, Cm 6305 (The Stationery Office, 2004).

²² *Ibid.*, cl 31(5)(a), 39(6)(a), 42(6)(a), 43(6)(a).

²³ *Ibid.*, chapter 6.

²⁴ *Ibid.*, cl 46(2)(i).

treatment except in clearly and strictly defined exceptional circumstances. In short, *B* is rightly decided; but the thinking behind the law on the patient's right and interest in direct involvement with his or her care is profoundly problematic.

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